

Facility Name & ID Number CHEVY CHASE NRSRG & REHAB CTR # 0040592 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>322</u>	Skilled (SNF)	<u>322</u>	<u>117,530</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>322</u>	TOTALS	<u>322</u>	<u>117,530</u>	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>96,043</u>	<u>2,260</u>	<u>7,320</u>	<u>105,623</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>96,043</u>	<u>2,260</u>	<u>7,320</u>	<u>105,623</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.87%

D. How many bed-hold days during this year were paid by Public Aid?
3581 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 07/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/0194 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 41 and days of care provided 4362

Medicare Intermediary MUTUANL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CHEVY CHASE NRSRG & REHAB CTR # 0040592 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	357,650	123,885	11,620	493,155		493,155	36	493,191			1
2	Food Purchase		514,732		514,732	(69,478)	445,254	(110)	445,144			2
3	Housekeeping		70,485	485,979	556,464		556,464		556,464			3
4	Laundry		15,799		15,799		15,799		15,799			4
5	Heat and Other Utilities			255,763	255,763		255,763	(13,846)	241,917			5
6	Maintenance	86,825	38,800	134,148	259,773		259,773	2,444	262,217			6
7	Other (specify):*							45	45			7
8	TOTAL General Services	444,475	763,701	887,510	2,095,686	(69,478)	2,026,208	(11,432)	2,014,777			8
	B. Health Care and Programs											
9	Medical Director			27,000	27,000		27,000		27,000			9
10	Nursing and Medical Records	3,219,096	182,751	49,357	3,451,204		3,451,204	(11,149)	3,440,055			10
10a	Therapy	78,085		8,125	86,210		86,210		86,210			10a
11	Activities	107,042	15,970	1,752	124,764		124,764		124,764			11
12	Social Services	98,766		2,976	101,742		101,742		101,742			12
13	Nurse Aide Training	5,362	97	285	5,744		5,744		5,744			13
14	Program Transportation			2,255	2,255		2,255	526	2,781			14
15	Other (specify):*							104	104			15
16	TOTAL Health Care and Programs	3,508,351	198,818	91,750	3,798,919		3,798,919	(10,519)	3,788,400			16
	C. General Administration											
17	Administrative	171,404		836,938	1,008,342		1,008,342	(648,025)	360,317			17
18	Directors Fees											18
19	Professional Services			89,105	89,105	(13,250)	75,855	(491)	75,364			19
20	Dues, Fees, Subscriptions & Promotions			71,117	71,117		71,117	(39,821)	31,296			20
21	Clerical & General Office Expenses	215,673	41,441	99,077	356,191		356,191	174,655	530,846			21
22	Employee Benefits & Payroll Taxes			730,513	730,513	69,478	799,991	(5,182)	794,809			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,412	14,412		14,412	(8,022)	6,390			24
25	Other Admin. Staff Transportation			1,364	1,364		1,364	487	1,851			25
26	Insurance-Prop.Liab.Malpractice			203,114	203,114		203,114	844	203,958			26
27	Other (specify):*							43,722	43,722			27
28	TOTAL General Administration	387,077	41,441	2,045,640	2,474,158	56,228	2,530,386	(481,832)	2,048,554			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,339,903	1,003,960	3,024,900	8,368,763	(13,250)	8,355,513	(503,782)	7,851,731			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			106,351	106,351		106,351	133,750	240,101			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,024	56,024		56,024	1,084,877	1,140,901			32
33	Real Estate Taxes			438,181	438,181	13,250	451,431		451,431			33
34	Rent-Facility & Grounds			1,802,071	1,802,071		1,802,071	(1,785,618)	16,453			34
35	Rent-Equipment & Vehicles			6,878	6,878		6,878	12,399	19,277			35
36	Other (specify):*			9,312	9,312		9,312		9,312			36
37	TOTAL Ownership			2,418,817	2,418,817	13,250	2,432,067	(554,592)	1,877,475			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	19,946	228,554	211,732	460,232		460,232	(3,318)	456,914			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			176,295	176,295		176,295		176,295			42
43	Other (specify):*	18,914			18,914		18,914	(18,914)	(0)			43
44	TOTAL Special Cost Centers	38,860	228,554	388,027	655,441		655,441	(22,232)	633,209			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,378,763	1,232,514	5,831,744	11,443,021		11,443,021	(1,080,606)	10,362,415			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(231,488)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(110)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(890)	21		18
19	Entertainment	(10,121)	24		19
20	Contributions	(20,125)	20		20
21	Owner or Key-Man Insurance	(5,182)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,000)	21		24
25	Fund Raising, Advertising and Promotional	(20,497)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,375)	20		28
29	Other-Attach Schedule	(82,554)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (412,343)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(668,263)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (668,263)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,080,606)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0040592

Report Period Beginning:01/01/01

Ending:12/31/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
	Reference		
1	C.O.P.E.	\$ (2,361)	20
2	INTEREST INCOME	(316)	32
3	MARKETING SALARY	(18,914)	43
4	BANK CHARGE	(10,245)	21
5	CABLE - RESIDENT ROOMS	(14,983)	5
6	PHARMACY - VETERAN	(12,121)	10
7	VETERANS MEDICAL EXPENSES	(182)	10
8	XRAY-VETERAN	(50)	10
9	CONCENTRATORS - VETERAN	(65)	10
10	PRIOR YEAR PHARMACY EXP SETTLEMENT	(3,376)	39
11	PART B COINSURANCE W/O - OT	(7,425)	21
12	PART B COINSURANCE W/O - PT	(7,630)	21
13	PART B COINSURANCE W/O - ST	(1,575)	21
14	CUT OF PERIOD LEGAL EXPENSE	(701)	19
15	NON-ALLOWABLE COLLECTION LEGAL FEE	(2,610)	19
16			16
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number CHEVY CHASE NRSNG & REHAB CTR# 0040592

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			36									36	1
2	Food Purchase	(110)											(110)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(14,983)		1,137									(13,846)	5
6	Maintenance			2,444									2,444	6
7	Other (specify):*			45									45	7
8	TOTAL General Services	(15,094)		3,662									(11,432)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(12,418)		1,269									(11,149)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			526									526	14
15	Other (specify):*			104									104	15
16	TOTAL Health Care and Programs	(12,418)		1,899									(10,519)	16
	C. General Administration													
17	Administrative			2,385	(629,803)		(20,607)						(648,025)	17
18	Directors Fees													18
19	Professional Services	(3,311)		1,896			924						(491)	19
20	Fees, Subscriptions & Promotions	(48,359)		1,060			7,478						(39,821)	20
21	Clerical & General Office Expenses	(63,766)		236,090			2,331						174,655	21
22	Employee Benefits & Payroll Taxes	(5,182)											(5,182)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(10,121)		2,072			27						(8,022)	24
25	Other Admin. Staff Transportation			487									487	25
26	Insurance-Prop.Liab.Malpractice			844									844	26
27	Other (specify):*			34,798	4,305		4,619						43,722	27
28	TOTAL General Administration	(130,738)		279,632	(625,498)		(5,228)						(481,832)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(158,249)		285,193	(625,498)		(5,228)						(503,782)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CHEVY CHASE NRSG & REHAB CTR # 0040592 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(231,488)	357,880	7,358									133,750	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(316)	1,089,453	(4,260)									1,084,877	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,802,071)	16,453									(1,785,618)	34
35	Rent-Equipment & Vehicles			12,399									12,399	35
36	Other (specify):*													36
37	TOTAL Ownership	(231,804)	(354,738)	31,950									(554,592)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(3,376)		58									(3,318)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(18,914)											(18,914)	43
44	TOTAL Special Cost Centers	(22,290)		58									(22,232)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(412,343)	(354,738)	317,201	(625,498)		(5,228)						(1,080,606)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Chevy Chase Assoc.	Chicago	Bldg Partnership

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	INTEREST EXPENSE	\$	CHEVY CHASE ASSOCIATES	100.00%	\$ 1,089,453	\$ 1,089,453	1
2	V	34	RENTAL INCOME	1,802,071	CHEVY CHASE ASSOCIATES	100.00%		(1,802,071)	2
3	V	30	DEPRECIATION EXPENSE		CHEVY CHASE ASSOCIATES	100.00%	357,880	357,880	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,802,071			\$ 1,447,333	\$ * (354,738)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	\$	NUCARE SERVICES CORP.	100.00%	\$ 36	\$ 36	15
16	V	5	UTILITIES		NUCARE SERVICES CORP.	100.00%	1,137	1,137	16
17	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	2,444	2,444	17
18	V	7	EMPLOYEE BEN. GEN. SERV.		NUCARE SERVICES CORP.	100.00%	45	45	18
19	V	10	NURSING ADMIN. COMP.		NUCARE SERVICES CORP.	100.00%	1,269	1,269	19
20	V	14	PROGRAM TRANSPORTATION		NUCARE SERVICES CORP.	100.00%	526	526	20
21	V	15	HEALTHCARE BENEFITS		NUCARE SERVICES CORP.	100.00%	104	104	21
22	V	17	ADMINISTRATIVE - NON-OWNER		NUCARE SERVICES CORP.	100.00%	2,385	2,385	22
23	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	1,896	1,896	23
24	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,060	1,060	24
25	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	236,090	236,090	25
26	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	2,072	2,072	26
27	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	487	487	27
28	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	844	844	28
29	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	34,798	34,798	29
30	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	7,358	7,358	30
31	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	(4,260)	(4,260)	31
32	V	34	BUILDING RENT		NUCARE SERVICES CORP.	100.00%	16,453	16,453	32
33	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	12,399	12,399	33
34	V	39	ANCILLARY		NUCARE SERVICES CORP.	100.00%	58	58	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 317,201	\$ * 317,201	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - R. HARTMAN	\$	NUCARE SERVICES CORP.	100.00%	\$ 125,844	\$ 125,844	15
16	V	17	ADMIN. - B. CARR		NUCARE SERVICES CORP.	100.00%	31,094	31,094	16
17	V	17	ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	3,253	3,253	17
18	V	17	ADMIN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%			18
19	V	27	EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	2,715	2,715	19
20	V	27	EMP. BEN. - B. CARR		NUCARE SERVICES CORP.	100.00%	1,336	1,336	20
21	V	27	EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	254	254	21
22	V								22
23	V								23
24	V								24
25	V	17	MANAGEMENT FEES	789,994	NUCARE SERVICES CORP.	100.00%		(789,994)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 789,994			\$ 164,496	\$ * (625,498)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	WORKERS' COMPENSATION	\$ 52,674	DIAMOND INSURANCE	20.00%	\$ 52,674	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 52,674			\$ 52,674	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 26,337	\$ 26,337	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK	100.00%	924	924	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK	100.00%	7,478	7,478	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK	100.00%	2,331	2,331	18
19	V	24	SEMINARS		CAREPATH HEALTH NETWORK	100.00%	27	27	19
20	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK	100.00%	4,619	4,619	20
21	V								21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	46,944	CAREPATH HEALTH NETWORK	100.00%		(46,944)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 46,944			\$ 41,716	\$ * (5,228)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CHEVY CHASE NRSG & REHAB CTR # 0040592 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Hartman	Owner	Administrative	60.75%	See attached	6.38	9.82%	Alloc. Salary	\$ 125,844	17-7	1
2	Barry Carr	Owner	Administrative	4.75%	See attached	7.00	15.56%	Alloc. Salary	31,094	17-7	2
3	David Hartman	Relative	Administrative	none	See attached	0.90	2.00%	Alloc. Salary	3,253	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 160,191		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CHEVY CHASE NRSG & REHAB CTR # 0040592 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number CHEVY CHASE NRSG & REHAB CTR# 0040592

Report Period Beginning:

01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

NUCARE SERVICES CORP.

Street Address

6677 N LINCOLN AVENUE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 933-2600

Fax Number

(847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAIL. CENSUS DAYS	672,540	8	\$ 205	\$ 117,530	117,530	\$ 36	1
2	5	UTILITIES	AVAIL. CENSUS DAYS	672,540	8	6,508	117,530	117,530	1,137	2
3	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	672,540	8	13,988	1,054	117,530	2,444	3
4	7	EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	672,540	8	258		117,530	45	4
5	10	NURSING ADMIN. COMP.	AVAIL. CENSUS DAYS	672,540	8	7,261	2,431	117,530	1,269	5
6	14	PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	672,540	8	3,009		117,530	526	6
7	15	HEALTHCARE BENEFITS	AVAIL. CENSUS DAYS	672,540	8	595		117,530	104	7
8	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS	672,540	8	13,648	8,000	117,530	2,385	8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	672,540	8	10,851		117,530	1,896	9
10	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	672,540	8	6,065		117,530	1,060	10
11	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	672,540	8	1,350,975	1,102,702	117,530	236,090	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	672,540	8	11,855		117,530	2,072	12
13	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	672,540	8	2,788		117,530	487	13
14	26	INSURANCE	AVAIL. CENSUS DAYS	672,540	8	4,831		117,530	844	14
15	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	672,540	8	199,124		117,530	34,798	15
16	30	DEPRECIATION	AVAIL. CENSUS DAYS	672,540	8	42,107		117,530	7,358	16
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	672,540	8	(24,377)		117,530	(4,260)	17
18	34	BUILDING RENT	AVAIL. CENSUS DAYS	672,540	8	94,150		117,530	16,453	18
19	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	672,540	8	70,953		117,530	12,399	19
20	39	ANCILLARY	AVAIL. CENSUS DAYS	672,540	8	335	269	117,530	58	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,815,129	\$ 1,114,456		\$ 317,201	25

Facility Name & ID Number CHEVY CHASE NRSG & REHAB CTR# 0040592

Report Period Beginning:

01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

NUCARE SERVICES CORP.

Street Address

6677 N LINCOLN AVENUE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 933-2600

Fax Number

(847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	36.52	8	720,115	720,000	6.38	125,844	1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	40.00	8	177,679	175,000	7.00	31,094	2
3	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	5.00	8	18,073	17,000	0.90	3,253	3
4	17	ADMIN. - E. DICKMAN	AVG. HOURS WORKED	35.00	1	20,728	19,166			4
5	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	36.52	8	15,535		6.38	2,715	5
6	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	40.00	8	7,632		7.00	1,336	6
7	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	5.00	8	1,411		0.90	254	7
8	27	EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	35.00	1	1,576				8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 962,749	\$ 931,166		\$ 164,496	25

Facility Name & ID Number CHEVY CHASE NRSG & REHAB CTR # 0040592 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DIAMOND INSURANCE
Street Address 40 SKOKIE BLVD - SUITE 105
City / State / Zip Code NORTHBROOK, IL 60062
Phone Number (847) 559-1002
Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	DIAMOND INSURANCE	DIRECT ALLOCATION			\$	\$		\$ 52,674	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 52,674	25

Facility Name & ID Number CHEVY CHASE NRSG & REHAB CTR # 0040592 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CAREPATH HEALTH NETWORK
Street Address 6633 N LINCOLN AVENUE
City / State / Zip Code LINCOLNWOOD, IL 60712
Phone Number (888) 707-6700
Fax Number (847) 679-2150

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	629,760	13	\$ 353,316	\$ 353,316	46,944	\$ 26,337	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	629,760	13	12,396		46,944	924	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	629,760	13	100,317		46,944	7,478	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	629,760	13	31,275		46,944	2,331	4
5	24	SEMINARS	CARE PATH FEES	629,760	13	366		46,944	27	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	629,760	13	61,960		46,944	4,619	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 559,630	\$ 353,316		\$ 41,716	25

Facility Name & ID Number CHEVY CHASE NRSG & REHAB CTR # 0040592 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number CHEVY CHASE NRSG & REHAB CTR # 0040592 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number CHEVY CHASE NRSG & REHAB CTR # 0040592 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number CHEVY CHASE NRSG & REHAB CTR # 0040592 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number CHEVY CHASE NRSG & REHAB CTR # 0040592 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	SHAREHOLDER LOAN	X		WORKING CAPITAL	INT ONLY			1,500,000	Renewal	Prime +1	56,024		6
7													7
8													8
9	TOTAL Facility Related						\$	1,500,000			\$	56,024	9
	B. Non-Facility Related*												
10	See Supplemental Schedule										1,084,877		10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	1,084,877	14
15	TOTALS (line 9+line14)						\$	1,500,000			\$	1,140,901	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
1	Interest Income		X				\$					\$ (316)	1
2	Allocation from NuCare	X										(4,260)	2
3	Chevy Chase Assoc.	X										1,089,453	3
4													4
5													5
6													6
7													7
8													8
9													9
10													10
11													11
12													12
13													13
14													14
15													15
16													16
17													17
18													18
19													19
20													20
21							\$		\$			\$ 1,084,877	21

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

CHEVY CHASE NRSG & REHAB CTR

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0040592

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A.

Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1.	17-34-119-049-0000	Long Term Care Property	\$ 297,333.07	\$ 297,333.07
2.	17-34-119-048-0000	Long Term Care Property	\$ 147,951.98	\$ 147,951.98
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 445,285.05	\$ 445,285.05

B.

Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C.

Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	80,457	1984	\$ 240,000	1
2					2
3	TOTALS	80,457		\$ 240,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1994		17,938		20	897	897	6,413	9
10	Various		1995		20,890		20	1,044	1,044	6,835	10
11	Various		1996		87,605		20	4,381	4,381	23,609	11
12	Various		1997		40,122		20	2,037	(2,037)	9,633	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$ -	\$	\$ -	37
38					-		-	38
39					-		-	39
40					-		-	40
41					-		-	41
42					-		-	42
43					-		-	43
44					-		-	44
45					-		-	45
46					-		-	46
47					-		-	47
48					-		-	48
49					-		-	49
50					-		-	50
51					-		-	51
52					-		-	52
53					-		-	53
54					-		-	54
55					-		-	55
56					-		-	56
57					-		-	57
58					-		-	58
59					-		-	59
60					-		-	60
61					-		-	61
62					-		-	62
63					-		-	63
64					-		-	64
65					-		-	65
66					-		-	66
67					-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)	4,738,503	358,097		137,986	(220,111)	2,011,034	68
69	Financial Statement Depreciation		22,081			(22,081)		69
70	TOTAL (lines 4 thru 69)	\$ 4,905,058	\$ 380,178		\$ 146,345	\$ (237,907)	\$ 2,057,524	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,905,058	\$ 380,178		\$ 146,345	\$ (233,833)	\$ 2,057,524	1
2	CCTV SYSTEM	1998	1,320		20	66	66	264	2
3	EMERGENCY ELECTRICIT	1998	7,770		20	389	389	1,556	3
4	INTERNAL WIRING	1998	1,992		20	100	100	367	4
5	CARPET & WALLCOVER	1998	6,838		20	342	342	1,254	5
6	ROOF REPAIR	1998	2,315		20	116	116	396	6
7	PARKING LOT REPAIR	1998	4,600		20	230	230	805	7
8	STEEL DOORS	1998	4,135		20	207	207	707	8
9	MONITORING SYSTEM	1998	3,282		20	164	164	560	9
10	CCTV SYSTEM	1998	1,405		20	70	70	239	10
11	GENERATOR REPAIR	1998	2,839		20	142	142	450	11
12	HANDRAIL & GUARDS	1998	2,159		20	108	108	360	12
13	ROOM REPAIRS	1998	2,523		20	126	126	410	13
14	2ND FLOOR-PAINT	1998	20,400		20	1,020	1,020	3,230	14
15	FLOORING	1998	1,362		20	68	68	215	15
16	CORAL GRANITE	1998	757		20	38	38	120	16
17	LIGHT FIXTURES	1998	2,040		20	102	102	323	17
18	WALLPAPER	1998	19,913		20	996	996	3,154	18
19	HANDRAIL & GUARD	1998	7,203		20	360	360	1,140	19
20	CUBICLE CURTAINS	1998	1,297		20	65	65	206	20
21	WALLPAPER	1998	800		20	40	40	123	21
22	FLOORING & BORDERS	1998	3,793		20	190	190	586	22
23	RECEPTION STATION	1998	5,675		20	284	284	876	23
24	CUBICLE CURTAIN	1998	11,272		20	564	564	1,880	24
25	NURSES CALL SYS R&M	1998	698		20	35	35	137	25
26	TELEPHONE LINES	1998	506		20	25	25	98	26
27	CCTV SYSTEM R&M	1998	958		20	48	48	180	27
28	TELEPHONE LINES	1998	768		20	38	38	143	28
29	TELEPHONE LINES	1998	907		20	45	45	146	29
30	TELEPHONE LINES	1998	502		20	25	25	81	30
31	WALLPAPER-OFFICE	1998	2,870		20	144	144	540	31
32	WALLPAPER	1998	1,568		20	78	78	286	32
33	VERTICLE BLINDS	1998	716		20	36	36	132	33
34	TOTAL (lines 1 thru 33)		\$ 5,030,241	\$ 380,178		\$ 152,606	\$ (227,572)	\$ 2,078,488	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,030,241	\$ 380,178		\$ 152,606	\$ (227,572)	\$ 2,078,488	1
2	WALLPAPER	1998	5,825		20	291	291	970	2
3	WALL BORDERS	1998	613		20	31	31	101	3
4	WALLPAPER	1998	1,114		20	56	56	177	4
5	WALLPAPER-2ND FLR	1999	10,885		20	544	544	1,632	5
6	WALLPAPER-PHASE II	1999	4,960		20	248	248	744	6
7	CERAMIC TILE	1999	2,452		20	123	123	369	7
8	RECEPTION STATION	1999	6,157		20	308	308	924	8
9	FIRE ALARM SYSTEM	1999	221,434		20	11,072	11,072	23,067	9
10	CURTAINS & DRAPES	1999	9,676		20	484	484	1,412	10
11	FIREPROOFING	1999	4,725		20	236	236	688	11
12	AIR BALANCE MODEL	1999	1,213		20	61	61	173	12
13	INTERCOM SYSTEM	1999	744		20	37	37	105	13
14	ALARM SYSTEM-2ND FLR	1999	1,146		20	57	57	162	14
15	ALARM SYSTEM-1ST FLR	1999	1,146		20	57	57	162	15
16	HANDRAILS & BUMPER	1999	4,750		20	238	238	694	16
17	ROOM SIGNAGES	1999	1,182		20	59	59	162	17
18	CUBICLE TRACK	1999	282		20	14	14	41	18
19	UNDERGROUND TANK	1999	2,500		20	125	125	354	19
20	WALL COVERING &BORDE	1999			20				20
21	DRAPERY	1999	530		20	27	27	72	21
22	TELEPHONE WIRING	1999	809		20	40	40	113	22
23	ALARM SYSTEM-3&4 FLR	1999	2,127		20	106	106	265	23
24	PAINT,WALLPAPER BORD	1999			20				24
25	UNDERGROUND TANK	1999	22,123		20	1,106	1,106	2,673	25
26	DRAPERIES	1999	474		20	24	24	58	26
27	LIGHT FIXTURES	1999	5,014		20	251	251	607	27
28	WALLPAPER	1999	1,187		20	59	59	143	28
29	CUBICLE CURTAINS	1999	24,451		20	1,223	1,223	2,854	29
30	COVE BASE	1999	1,319		20	66	66	154	30
31	TELEPHONE WIRING	1999	1,195		20	60	60	145	31
32	TELEPHONE WIRING	1999	624		20	31	31	72	32
33	CONTAINMENT BASIN	1999	2,430		20	122	122	285	33
34	TOTAL (lines 1 thru 33)		\$ 5,373,328	\$ 380,178		\$ 169,762	\$ (210,416)	\$ 2,117,866	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,373,328	\$ 380,178		\$ 169,762	\$ (210,416)	\$ 2,117,866	1
2	BORDER	1999	747		20	37	37	83	2
3	WINDOW TREATMENT	1999	895		20	45	45	101	3
4	ALARM SYSTEM	1999	255		20	13	13	29	4
5	HEATER	1999	8,250		20	413	413	895	5
6	CARPET	1999	369		20	18	18	39	6
7	DOORS & FRAMES	1999	1,086		20	54	54	117	7
8	KITCHEN AMPLIFIER	1999	738		20	37	37	80	8
9	TELEPHONE LINE-LAUND	1999	582		20	29	29	63	9
10	TELE LINE-RECEPTION	1999	604		20	30	30	63	10
11	TELE LINE-DIETARY	1999	762		20	38	38	79	11
12	SHOWER REPAIR	1999	1,278		20	64	64	139	12
13	PUMP SHAFT	1999	450		20	23	23	48	13
14	NURSES CALL SYSTEM	1999	1,021		20	51	51	123	14
15	PAGING SYSTEM	1999	759		20	38	38	92	15
16	CCTV SYSTEM	1999	751		20	38	38	79	16
17	ALARM-FLOWS & TAMPER	1999	3,240		20	162	162	378	17
18	SMOKE DETECTORS	1999	2,580		20	129	129	301	18
19	TIME-WALK IN FREEZER	1999	671		20	34	34	74	19
20	ALARM-LEGAL	1999	135		20	7	7	15	20
21	ALARM-LEGAL	1999	222		20	11	11	23	21
22	ALARM-IDPH	1999	2,400		20	120	120	250	22
23	BOILER	1999	2,517		20	126	126	378	23
24	WATER TANKS	1999	500		20	25	25	52	24
25	ELEVATOR DOOR	1999	5,850		20	293	293	610	25
26	WINDOW TREATMENTS	1999	1,145		20	57	57	171	26
27	LIGHT FIXTURES	1999	676		20	34	34	102	27
28	CABINETS	1999	25,600		20	1,280	1,280	3,307	28
29	PAINTING	1999	1,234		20	62	62	171	29
30	PLUMBING	1999	740		20	37	37	108	30
31	WALL COVERING PAINT	1999	18,196		20	910	910	1,820	31
32	FIRE ALARM PANEL	2000	1,900		20	95	95	182	32
33	CORNER GUARDS	2000	116		20	6	6	11	33
34	TOTAL (lines 1 thru 33)		\$ 5,459,597	\$ 380,178		\$ 174,078	\$ (206,100)	\$ 2,127,849	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,459,597	\$ 380,178		\$ 174,078	\$ (206,100)	\$ 2,127,849	1
2	INSTL ELEC PANEL DEV	2000	926		20	46	46	81	2
3	TEMPORARY TANK RENTL	2000			20				3
4	REPL SPRINKLER HEADS	2000	560		20	28	28	51	4
5	FREIGHT-INV #18476	2000	123		20	6	6	10	5
6	INSTALL ALARM SYSTEM	2000	1,233		20	62	62	109	6
7	WANDER GUARD SYSTEM	2000	11,180		20	559	559	1,118	7
8	IN HOUSE PAGING SYS	2000	3,511		20	176	176	323	8
9	SPRINKLER SYS REPAIR	2000	1,109		20	55	55	110	9
10	WINDOWS	2000	875		20	44	44	88	10
11	INSTALL WIRELESS NUR	2000	3,238		20	162	162	189	11
12	INST HOOKUP 4 DIAL M	2000	19,600		20	980	980	1,470	12
13	SERV ON ALARM SYSTEM	2000	980		20	49	49	90	13
14	INSTALL ELEC STRIKER	2000	638		20	32	32	56	14
15	REPAIR A/C SYSTEM	2000	1,387		20	69	69	98	15
16	REBUILT HEAT EXCHANG	2000	1,598		20	80	80	113	16
17	FIRE DAMPER CLEANING	2000	1,450		20	73	73	103	17
18	COUNTERS	2000	907		20	45	45	56	18
19	82 OVERBED FIXTURES	2000	5,904		20	295	295	393	19
20	83 OVERBED FIXTURES	2000	5,976		20	299	299	374	20
21	LOCKS	2000	705		20	35	35	47	21
22	SAFETY LOC SYSTEM	2000	16,200		20	810	810	945	22
23	ELEVATOR WORK	2000	1,300		20	65	65	70	23
24	ELEVATOR WORK	2000	586		20	29	29	39	24
25	CCTV SYSTEM	2000	1,079		20	54	54	72	25
26	PHONE WIRING	2000	867		20	43	43	57	26
27	FIRE ALARMS	2000	632		20	32	32	40	27
28	OVERBED FIXTURES	2000	3,888		20	194	194	210	28
29	TELEPHONE SYS SERV.	2000	992		20	50	50	71	29
30	FIRE ALARM REPAIR	2000	1,144		20	57	57	76	30
31	WANDERGAURD	2001	1,310		20	66	66	66	31
32	COMPRESSOR	2001	6,412		20	268	268	268	32
33	DOOR ALARM	2001	950		20	36	36	36	33
34	TOTAL (lines 1 thru 33)		\$ 5,556,857	\$ 380,178		\$ 178,877	\$ (201,301)	\$ 2,134,678	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 5,556,857	\$ 380,178		\$ 178,877	\$ (201,301)	\$ 2,134,678	1
2	NURSING STATION	2001	11,700		20	439	439	439	2
3	PHONE OUTLET	2001	967		20	28	28	28	3
4	ELECTRICAL CIRCUIT	2001	642		20	19	19	19	4
5	WALLPAPER	2001	12,039		20	351	351	351	5
6	WALLPAPER	2001	663		20	14	14	14	6
7	WANDERGUARD	2001	1,344		20	22	22	22	7
8	WALLPAPER	2001	7,611		20	191	191	191	8
9	WATER HEATER	2001	4,330		20	72	72	72	9
10	FIRE ALARM REPAIR	2001	1,087		20	18	18	18	10
11	DRAIN OUTLET	2001	850		20	18	18	18	11
12	WALLPAPER	2001	751		20	13	13	13	12
13	PHONE LINES	2001	983		20	12	12	12	13
14	PHONES LINES	2001	858		20	11	11	11	14
15	FIRE PROOF BOARD	2001	375		20	3	3	3	15
16	CURTAIN & RODS	2001	3,854		20	48	48	48	16
17	WALLPAPER	2001	1,072		20	9	9	9	17
18	PAINTING	2001	2,376		20	10	10	10	18
19	FIRE ALARM REPAIRS	2001	749		20	3	3	3	19
20	CURTAINS & RODS	2001	7,792		20	33	33	33	20
21	SIGNS	2001	2,466		20	31	31	31	21
22	WALLPAPER	2001	5,096		20	85	85	85	22
23	WALLPAPER	2001	5,109		20	85	85	85	23
24	PHONE LINES	2001	774		20	3	3	3	24
25	PHONE & FAX LINES	2001	515		20	2	2	2	25
26	NURSE CALL SYSTEM	2001	2,873		20	12	12	12	26
27	PHONE LINES	2001	454		20	2	2	2	27
28	SPRINKLER SYS. REPAI	2001	725		20	27	27	27	28
29	PHONE LINE	2001	521		20	20	20	20	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,635,433	\$ 380,178		\$ 180,458	\$ (199,720)	\$ 2,136,259	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 5,635,433	\$ 380,178		\$ 180,458	\$ (199,720)	\$ 2,136,259	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,635,433	\$ 380,178		\$ 180,458	\$ (199,720)	\$ 2,136,259	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 5,635,433	\$ 380,178		\$ 180,458	\$ (199,720)	\$ 2,136,259	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,635,433	\$ 380,178		\$ 180,458	\$ (199,720)	\$ 2,136,259	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 5,635,433	\$ 380,178		\$ 180,458	\$ (199,720)	\$ 2,136,259	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,635,433	\$ 380,178		\$ 180,458	\$ (199,720)	\$ 2,136,259	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	322		1986	1977	\$ 4,471,948	\$ 357,880	35	\$ 127,770	\$ (230,110)	\$ 1,801,809	4
5			1984	1984	92,611		35	2,646	2,646	52,149	5
6							35			38,128	6
7											7
8											8
	Improvement Type**										
9	NUCARE ALLOCATION			1997	805	21	20	40	19	170	9
10	NUCARE ALLOCATION			1998	705	18	20	35	17	122	10
11	NUCARE ALLOCATION			1999	988	137	20	49	(88)	120	11
12	NUCARE ALLOCATION			2000	1,201	31	20	60	(29)	87	12
13	NUCARE ALLOCATION			2001	465	10	20	20	10	20	13
14	IMPROVEMENTS			1980	8,303		8			8,303	14
15	IMPROVEMENTS			1981	1,872		8			1,872	15
16	IMPROVEMENTS			1982	5,523		15			5,523	16
17	IMPROVEMENTS			1983	1,550		15			1,550	17
18	IMPROVEMENTS			1984	3,664		15			3,664	18
19	IMPROVEMENTS			1984	1,398		10			1,398	19
20	IMPROVEMENTS			1985	2,312		18	128	128	2,152	20
21	IMPROVEMENTS			1985	22,188		19	1,168	1,168	18,930	21
22	IMPROVEMENTS			1986	8,802		19	463	463	7,095	22
23	HUMIDIFIER			1987	2,325		10			2,325	23
24	BOILER			1987	1,819		20	91	91	1,342	24
25	HEAT PUMP			1987	1,007		15	67	67	955	25
26	DOOR LOCKS			1988	2,970		15	198	198	2,756	26
27	NURSES STATION			1988	2,217		20	111	111	1,545	27
28	ANTENA/PA SYSTEM			1988	1,426		15	95	95	1,314	28
29	CONTER TOP			1988	6,652		20	333	333	4,384	29
30	SUMP PUMP			1988	1,107		25	74	74	1,017	30
31	LEASEHOLD			1989	12,710		25	636	636	7,950	31
32	ROOFING			1989	43,000		15	2,150	2,150	26,875	32
33	IMPROVEMENTS			1990	4,899		20	245	245	2,817	33
34	IMPROVEMENTS			1991	9,582		20	479	479	5,030	34
35	IMPROVEMENTS			1992	2,610		20	131	131	1,243	35
36											36

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.
 See Page 12A-REP, Line 70 for total

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 IMPROVEMENTS	1992	\$ 2,224	\$	20	\$ 111	\$ 111	\$ 1,055	37
38 WATER HEATER	1993	10,250		20	513	513	4,360	38
39 CABLE REPAIR	1993	848		20	43	43	365	39
40 CABLE REPAIR	1993	250		20	13	13	110	40
41 WINDOW SAFETY CABLES	1993	1,437		20	72	72	612	41
42 LAUNDRY MOTOR	1993	1,000		20	50	50	425	42
43 IMPROVEMENTS	1994	5,835		20	195	195	1,462	43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 4,738,503	\$ 358,097		\$ 137,986	\$ (220,169)	\$ 2,011,034	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 582,172	\$ 90,098	\$ 57,569	\$ (32,529)	10	\$ 213,284	71
72	Current Year Purchases	50,755	1,313	2,074	761	10	2,086	72
73	Fully Depreciated Assets	720,486				10	720,486	73
74								74
75	TOTALS	\$ 1,353,413	\$ 91,411	\$ 59,643	\$ (31,768)		\$ 935,856	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
		Reference	Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,228,846 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 471,589 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 240,101 83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (231,488) 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,072,115 85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NuVision Holding, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1977	322	10/16/98	\$ 1,802,071			3
4	Additions Alloc. Fr. NuCare				16,453			4
5	Chevy Chase Assoc.				(1,802,071)			5
6								6
7	TOTAL		322		\$ 16,453			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 16,681 Description: NuCare alloc. \$12,399; Copier rental \$4,282;

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	1998 Jeep Cherokee	\$ 506	\$ 2,596	17
18					18
19					19
20					20
21	TOTAL		\$ 506	\$ 2,596	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	/2003	\$ 1,713,924
13.	/2004	\$ 1,713,924
14.	/2005	\$ 1,713,924

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☒

120

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☒

☐

80

B. EXPENSES

ALLOCATION OF COSTS (d)

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	<u>7</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>1</u>
2. From other facilities (f)	
TOTAL TRAINED	8

		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$ 285	\$	\$	\$ 285
2	Books and Supplies	97			97
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	670	4,692		5,362
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 1,052	\$ 4,692	\$	\$ 5,744
10	SUM OF line 9, col. 1 and 2 (e)	\$ 5,744			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	102,196	\$		\$ 102,196	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				9,792			9,792	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				99,744			99,744	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 02	# of prescripts					153,780		153,780	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):				19,946			74,774		94,720	13
14	TOTAL			\$ 19,946		\$ 211,732	\$ 228,554		\$ 460,232	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 34,274	\$	1
2	Cash-Patient Deposits	13,236		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,264,708		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	115,304		6
7	Other Prepaid Expenses	2,089		7
8	Accounts Receivable (owners or related parties)	2,812,151		8
9	Other(specify): See supplemental schedule	229,029		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,470,791	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	925,432		15
16	Equipment, at Historical Cost	577,568		16
17	Accumulated Depreciation (book methods)	(518,297)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	72,483		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,057,186	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,527,977	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,688,659	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,761		28
29	Short-Term Notes Payable	1,500,000		29
30	Accrued Salaries Payable	321,091		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,692		31
32	Accrued Real Estate Taxes(Sch.IX-B)	467,550		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	28,760		35
	Other Current Liabilities(specify):			
36	See supplemental schedule	5,684		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,042,197	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,042,197	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,485,780	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,527,977	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,795,460	1
2	Restatements (describe):		2
3	Adj to Allowance for Doubtful Accounts	(50,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,745,460	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	740,320	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 740,320	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,485,780	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **CHEVY CHASE NRSG & REHAB CTR**# **0040592**Report Period Beginning: **01/01/01**

Ending:

12/31/01**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,713,285	1
2	Discounts and Allowances for all Levels	(213,772)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,499,513	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	383,046	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 383,046	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	245,495	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,872	19
20	Radiology and X-Ray		20
21	Other Medical Services	31,099	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 300,466	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	316	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 316	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,183,341	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,095,686	31
32	Health Care	3,798,919	32
33	General Administration	2,474,158	33
	B. Capital Expense		
34	Ownership	2,418,817	34
	C. Ancillary Expense		
35	Special Cost Centers	479,146	35
36	Provider Participation Fee	176,295	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,443,021	40
41	Income before Income Taxes (line 30 minus line 40)**	740,320	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 740,320	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number CHEVY CHASE NRSG & REHAB CTR# 0040592

Report Period Beginning:

01/01/01

Ending:

12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,580	2,804	\$ 91,744	\$ 32.72	1
2	Assistant Director of Nursing	1,095	1,133	31,408	27.73	2
3	Registered Nurses	23,987	26,935	568,008	21.09	3
4	Licensed Practical Nurses	60,422	66,683	1,094,161	16.41	4
5	Nurse Aides & Orderlies	160,151	172,793	1,374,720	7.96	5
6	Nurse Aide Trainees	551	551	5,362	9.74	6
7	Licensed Therapist	888	888	19,946	22.46	7
8	Rehab/Therapy Aides	9,118	10,481	78,085	7.45	8
9	Activity Director	1,860	2,166	29,918	13.81	9
10	Activity Assistants	9,254	10,326	77,124	7.47	10
11	Social Service Workers	8,181	9,074	98,766	10.88	11
12	Dietician	3,309	3,759	69,735	18.55	12
13	Food Service Supervisor					13
14	Head Cook	7,867	8,701	83,112	9.55	14
15	Cook Helpers/Assistants	27,747	29,721	204,803	6.89	15
16	Dishwashers					16
17	Maintenance Workers	4,416	4,886	86,825	17.77	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,748	2,886	125,107	43.35	20
21	Assistant Administrator	478	745	18,220	24.45	21
22	Other Administrative	562	562	28,077	49.96	22
23	Office Manager					23
24	Clerical	13,629	15,450	215,673	13.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	975	1,065	13,323	12.51	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,102	2,502	45,732	18.28	31
32	Other Health Care(specify)					32
33	Other(specify)	536	581	18,914	32.55	33
34	TOTAL (lines 1 - 33)	342,454	374,691	\$ 4,378,763 *	\$ 11.69	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	283	\$ 11,620	01-03	35
36	Medical Director	Flat Rate	27,000	09-03	36
37	Medical Records Consultant	Flat Rate	4,032	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Flat Rate	5,796	10-03	39
40	Physical Therapy Consultant	103	5,125	10a-03	40
41	Occupational Therapy Consultant	60	3,000	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,752	11-03	44
45	Social Service Consultant	58	2,976	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	539	\$ 61,301		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	179	\$ 7,052	10-03	50
51	Licensed Practical Nurses	893	32,477	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,072	\$ 39,529		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Barbara Casey 01/01/01 - 12/31/01	Administrator	0%	\$ 87,097	Workers' Compensation Insurance	\$	52,674	IDPH License Fee	\$
Farhat Sharif 01/01/01 - 12/31/01	VP of Operations	0%	38,010	Unemployment Compensation Insurance		44,511	Advertising: Employee Recruitment	(154)
Mike Ramel 01/01/01 - 12/31/01	Asst Administrator	0%	18,220	FICA Taxes		320,344	Health Care Worker Background Check	
Kathy Brander (Nucare)	Dir of Regulatory Mgmt	0%	23,291	Employee Health Insurance		100,738	(Indicate # of checks performed 221)	1,790
Ray Dolan (Nucare)	VP of Risk Mgmt	0%	4,786	Employee Meals		69,478	Yellow page advertising	5,375
				Illinois Municipal Retirement Fund (IMRF)*			License, Inspection & Permits	3,696
				Payroll Taxes Reimbursed		18,180	Dues & Subscriptions	17,426
TOTAL (agree to Schedule V, line 17, col. 1)				Union Health Insurance		112,796	Promotional Advertising	20,497
(List each licensed administrator separately.)			\$ 171,404	Union Pension Benefits		26,410	Allocation from NuCare	1,060
B. Administrative - Other				Dental Insurance		1,731	Allocation from CarePath	7,478
Description	Amount			Employee Benefits		36,438	Less: Public Relations Expense	
Management Fees - NuCare Services	\$ 789,994			401k Matching Expense		3,270	Non-allowable advertising	(20,497)
Management Fees - CarePath	46,944			Chicago Head Taxes		8,240	Yellow page advertising	(5,375)
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 794,809	TOTAL (agree to Sch. V, line 20, col. 8)	
							\$ 31,296	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 836,938	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type	Amount						
Various - See attached	Legal	\$ 28,841					In-State Travel	
Frost, Ruttenberg & Rothblatt	Accounting	25,587						
Power Software	Computer	11,150						
Horizon Healthcare Tech	Computer	5,255						
Health Data System	Data Processing	6,492						
AOL Online	Computer	66						
Mutual of Omaha	Computer	553						
First Real Estate Service	Appraisal-reclass to R/E Tax	3,250					Seminar Expense	4,291
Personnel Planner	Unemployment Consultant	6,710					Allocation from NuCare	2,072
Purchasing Plus	Purchasing Service	1,200					Allocation from CarePath	27
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 89,105				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 6,390

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Painting and Decorating	07/95	\$ 4,733	3	\$ 788	\$	\$	\$	\$	\$	\$	\$	\$
2	HVAC Repair	07/95	8,267	3	1,377								
3													
4													
5													
6													
7													
8													
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16													
17													
18													
19													
20	TOTALS		\$ 13,000		\$ 2,165	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number		CHEVY CHASE NRSG & REHAB CTR		STATE OF ILLINOIS			Page 23
#		0040592		Report Period Beginning:	01/01/01	Ending:	12/31/01

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

YES

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

YES
\$18,274 IL Council on Long Term Care

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

YES
YES

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

NO

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

YES
10 YEARS

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 15,024 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

YES

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

NO

(9)

Are you presently operating under a sublease agreement?

X YES NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X
Chevy Chase Nursing Center, #0034892, 07/01/94

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 176,295

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

NO

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

YES

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

NO

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 69,478
NO
Indicate the amount. \$ N/A

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

NO

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

NO
N/A

c.

What percent of all travel expense relates to transportation of nurses and patients?

100%ln 14

d.

Have vehicle usage logs been maintained?

N/A

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

YES

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

YES
N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?
If no, please explain.

NO
N/A
N/A

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

YES

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees

YES

11/7/2005 2:20 PM